

IC 12-15-15

Chapter 15. Payment to Hospitals; General

IC 12-15-15-1

Services at hospitals licensed under IC 16-21; rates established under rules

Sec. 1. Payment of a service provided in a hospital licensed under IC 16-21 shall be determined in accordance with a payment rate for the service that is established under rules adopted under IC 4-22-2 by the secretary in conjunction with the office.

As added by P.L.2-1992, SEC.9. Amended by P.L.27-1992, SEC.11; P.L.2-1993, SEC.93.

IC 12-15-15-1.1

Reimbursement to hospitals for inpatient hospital services; intergovernmental transfers; calculating Medicaid shortfall

Sec. 1.1. (a) This section applies to a hospital that is:

- (1) licensed under IC 16-21; and
- (2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

- (A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and
- (B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding

payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.
STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the state fiscal year's end. A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b). The office shall use the intergovernmental transfer to fund payments made under this section and as otherwise provided under IC 12-15-20-2(8).

(e) A hospital making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under STEP SEVEN of subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under STEP SEVEN of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP SEVEN of subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal

year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

As added by P.L.126-1998, SEC.4. Amended by P.L.113-2000, SEC.2; P.L.283-2001, SEC.19; P.L.66-2002, SEC.5; P.L.120-2002, SEC.13; P.L.1-2003, SEC.56; P.L.255-2003, SEC.16.

IC 12-15-15-1.3

Reimbursement to hospitals for outpatient hospital services; intergovernmental transfers; calculating Medicaid shortfall

Sec. 1.3. (a) This section applies to a hospital that is:

- (1) licensed under IC 16-21; and
- (2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount equal to one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in proportion to each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), the reimbursement for a state fiscal year under this section consists of payments made before December 31 following the end of the state fiscal year. A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer under this subsection, or an intergovernmental transfer may be made on behalf of the hospital, after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b). The office shall use the intergovernmental transfer to fund payments made under this section and as otherwise provided under IC 12-15-20-2(8).

(e) A hospital making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under STEP SEVEN of subsection (b). The periods described in subsections (c) and (d) for the hospital to make an intergovernmental transfer are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under STEP SEVEN of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP SEVEN of

subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision

(1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

As added by P.L.120-2002, SEC.14. Amended by P.L.255-2003, SEC.17.

IC 12-15-15-1.5

Additional reimbursements to certain hospitals; appeal of amount of distribution

Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were

provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payment, the first ten million dollars (\$10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than seventy thousand (70,000) Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services.

(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of

the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.

(c) Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of subsection (b). The distribution to other hospitals under STEP FIVE of subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

As added by P.L.255-2003, SEC.18.

IC 12-15-15-1.6

Alternative payment methodology for payments to hospitals

Sec. 1.6. (a) This section applies only if the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter will not be approved for federal financial participation.

(b) If the office determines that payments made under section 1.5(b) STEP FIVE (A) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (A) of this chapter if:

- (1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and
- (2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.

(c) If the office determines that payments made under section 1.5(b) STEP FIVE (B) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (B) of this chapter if:

- (1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (B) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.

(d) If the office determines that payments made under section 1.5(b) STEP FIVE (C) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (C) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of this chapter for that state fiscal year.

(e) If the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under subsection (b), (c), or (d) will not be approved for federal financial participation, the office shall use the funds that would have served as the nonfederal share of these payments for a state fiscal year to serve as the nonfederal share of a payment program for hospitals to be established by the office. The payment program must distribute payments to hospitals for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.

As added by P.L.78-2004, SEC.4.

IC 12-15-15-2

Rates adopted for hospital licensed under IC 16-21; prospective or retrospective application

Sec. 2. The rates adopted under this chapter for a hospital licensed under IC 16-21 may be the following:

(1) Prospective.

(2) Retroactive.

(3) A combination of prospective and retroactive.

As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.94.

IC 12-15-15-2.5

Payment for physician services in emergency department

Sec. 2.5. (a) Payment for physician services provided in the emergency department of a hospital licensed under IC 16-21 must be at a rate of one hundred percent (100%) of rates payable under the Medicaid fee structure.

(b) The payment under subsection (a) must be calculated using the same methodology used for all other physicians participating in the Medicaid program.

(c) For services rendered and documented in an individual's medical record, physicians must be reimbursed for federally required

medical screening exams that are necessary to determine the presence of an emergency using the appropriate Current Procedural Terminology (CPT) codes 99281, 99282, or 99283 described in the Current Procedural Terminology Manual published annually by the American Medical Association, without authorization by the enrollee's primary medical provider.

(d) Payment for all other physician services provided in an emergency department of a hospital to enrollees in the Medicaid primary care case management program must be at a rate of one hundred percent (100%) of the Medicaid fee structure rates, provided the service is authorized, prospectively or retrospectively, by the enrollee's primary medical provider.

(e) This section does not apply to a person enrolled in the Medicaid risk-based managed care program.

As added by P.L.153-1995, SEC.10. Amended by P.L.119-1997, SEC.5; P.L.245-1999, SEC.1; P.L.223-2001, SEC.10.

IC 12-15-15-3

Services provided at hospitals operating under IC 16-24-1; prospective payment rate

Sec. 3. Payment of a service provided in a hospital operating under IC 16-24-1 shall be determined in accordance with a prospective payment rate for the service.

As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.95.

IC 12-15-15-4

Per diem rate for services provided in hospitals operating under IC 16-24-1

Sec. 4. The office shall establish a per diem rate for the service provided in a hospital operating under IC 16-24-1 under rules adopted under IC 4-22-2 by the secretary.

As added by P.L.2-1992, SEC.9. Amended by P.L.2-1993, SEC.96.

IC 12-15-15-4.5

Payment for HIV test; limitation

Sec. 4.5. Payment to a hospital for a test required under IC 16-41-6-4 must be in an amount equal to the hospital's actual cost of performing the test and may not reduce or replace the reimbursement of other services that are provided to the patient under the state Medicaid program. The total cost to the state may not be more than twenty-four thousand dollars (\$24,000) in a state fiscal year.

As added by P.L.237-2003, SEC.2.

Repealed

(Repealed by P.L.126-1998, SEC.22.)

IC 12-15-15-6

Fees in addition to infant delivery fees

Sec. 6. (a) In addition to a payment due to a hospital for the delivery of a newborn infant, the office shall tender a payment to the

hospital for the hospital's collection, handling, and delivery of a specimen for testing under IC 16-41-17-2(a)(10).

(b) Payment to a hospital required under subsection (a) must be in an amount equal to the total of the following costs:

(1) The cost incurred by the hospital to collect, handle, and deliver the specimen obtained for testing under IC 16-41-17-2(a)(10).

(2) Any fee assessed against the hospital for a laboratory's testing of the specimen under IC 16-41-17-2(a)(10).

(3) Any newborn screening fee or other fee assessed against the hospital by the state department of health in connection with the testing of the specimen under IC 16-41-17-2(a)(10).

As added by P.L.149-2001, SEC.2.

IC 12-15-15-7

Reserved

IC 12-15-15-8

Repealed

(Repealed by P.L.126-1998, SEC.21.)

IC 12-15-15-9

Attribution of payable claim to county; amount of payment on payable claims; conditions on payments; funds available for payments

Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under this section.

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of a hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

(f) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total

amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

(g) Any county's funds identified in subsection (f) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(h) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

(i) For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(j) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

As added by P.L.126-1998, SEC.5. Amended by P.L.113-2000, SEC.3; P.L.283-2001, SEC.20; P.L.1-2002, SEC.52; P.L.120-2002, SEC.15; P.L.1-2003, SEC.57; P.L.255-2003, SEC.19; P.L.78-2004, SEC.5.

IC 12-15-15-9.5

Attribution of payable claim to county; funds available for payments; limitation on payments

Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under this section.

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not

exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:

(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and

(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.

The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.

(f) Except as provided in subsection (g), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(g) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(h) Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8)(D).

(i) For purposes of this section:

(1) "payable claim" has the meaning set forth in

IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

As added by P.L.255-2003, SEC.20. Amended by P.L.78-2004, SEC.6.

IC 12-15-15-9.6

Limitation on total amount of payments

Sec. 9.6. The total amount of payments to hospitals under sections 9 and 9.5 of this chapter may not exceed the amount transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

As added by P.L.255-2003, SEC.21.

IC 12-15-15-9.8

Alternative payment methodology for payable claims to hospitals

Sec. 9.8. (a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:

(1) section 9(c) of this chapter; or

(2) section 9.5(c) of this chapter;

will not be approved by the United States Centers for Medicare and Medicaid Services.

(b) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.

(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment

methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.

As added by P.L.78-2004, SEC.7.

IC 12-15-15-10

Payments to providers under Medicaid disproportionate share provider program

Sec. 10. (a) This section applies to a hospital that:

- (1) is licensed under IC 16-21; and
- (2) qualifies as a provider under the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

- (1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).
- (2) Establish a nominal charge hospital payment program.
- (3) Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

- (1) intergovernmental transfers; or
- (2) funds certified as being eligible for federal financial participation.

(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

As added by P.L.113-2000, SEC.4. Amended by P.L.66-2002, SEC.6.

IC 12-15-15-11

Nominal charge hospitals

Sec. 11. Hospitals licensed under IC 16-21 that are established and operated under IC 16-22, IC 16-22-8, or IC 16-23 are nominal charge hospitals for purposes of the Medicaid program.

As added by P.L.283-2001, SEC.21.